

ICPC WISCONSIN FINANCIAL / MEDICAL PLAN

Use of form: Complete this form for each child requested to be placed out of state. Completion of this form is voluntary, however, the information expedites the ICPC process.

Instructions: Send the completed form to: Wisconsin ICPC
Division of Children and Family Services
Bureau of Programs and Policies
P.O. Box 8916
Madison, WI 53708-8916

CHILD INFORMATION

Name - Child (Last, First, MI)

Birthdate (mm/dd/yyyy)

☐ Yes ☐ No Child is Title IV-E eligible.

Child placement - (Check one)

☐ Foster care ☐ With relatives outside the state of Wisconsin**FINANCIAL PLAN**

Placement resource is: (Check all that apply)

☐ Financially able and willing to support this child.☐ Entitled to receive Kinship Care payments from Wisconsin in the amount of \$215 per month per child.☐ Entitled to receive foster board payments from Wisconsin.

Wisconsin will pay foster care at the rate of \$ _____ per month for this child, upon licensure and placement approval from receiving state.

☐ Parent placement with court ordered supervision. Parent is financially responsible for child.☐ Other - Specify.**MEDICAL PLAN** (Check all that apply)☐ Child is IV-E eligible.

Receiving state will arrange for Medicaid coverage based on the provisions of the federal COBRA legislation (Title IV-E). Attach IV-E documentation, forms CFS-201 and CFS-205.

☐ Child is not IV-E eligible.

Sending agency will reimburse the placement resource for child's medical expenditures incurred with prior approval. Include billing and medical emergency instructions.

☐ Placement resource has agreed to provide financially for medical needs of child.☐ Parent placement with court ordered supervision. Parent will provide medically for child.☐ Other - Specify.

The Wisconsin sending agency remains ultimately financially responsible for the child and will retain jurisdiction of the child as mandated by Article 5 of ICPC (s. 48.988(5), Wis. Stats.). If the child needs to return to Wisconsin, the sending agency will pay the transportation costs and will expect the full cooperation from the receiving state to accomplish this return. This plan will be in effect following the placement of the child, and until approved termination of the placement consistent with the provisions of the Interstate Compact on the Placement of Children.

SIGNATURE - Social Worker_____
Date Signed_____
SIGNATURE - Supervisor_____
Date Signed